



COOPERATIVE OF
AMERICAN PHYSICIANS

ENTITY APPLICATION

APPLICATION FOR MUTUAL PROTECTION TRUST (MPT) COVERAGE FOR ENTITIES RELATED TO A MPT MEMBER'S PRACTICE

Entity is defined as:

A Health Facility, medical sole proprietorship, medical partnership, medical corporation, medical group, medical clinic, unincorporated association of Healthcare Practitioners, and/or any other personal, professional or business enterprise with which the MPT Member has any association or relationship.

Sender Instructions:

The completed Application with all attachments may be sent via:

Fax: 213-473-8773 or
Mail: Cooperative of American Physicians, Inc. (CAP)
Membership Underwriting Department
333 S. Hope Street, 8th Floor
Los Angeles, CA 90071-1409

In order to evaluate your application for Entity coverage, you must complete all requested information. Indicate "n/a" if a question is not applicable. Any answers left blank will result in a delay in the process of your application. A separate application must be submitted for each Entity for which you are seeking coverage.



APPLICATION FOR MUTUAL PROTECTION TRUST (MPT) COVERAGE
 FOR ENTITIES RELATED TO A MEMBER'S PRACTICE
 Page 3 of 14

2. ADDRESSES OF ENTITY *Please indicate the address type for each address listed, i.e., Office 1, Additional Office, Business Office, Billing Address.*

Circle Address Type	Primary Address: Ofc 1 – Add'l Ofc – Business – Billing – Other (specify type)	Ofc 1 – Add'l Ofc – Business – Billing – Other (specify type)
Street Address		
City, State ZIP		
Contact Person		
Phone Number(s)		
Fax Number(s)		
E-mail Address(s)/Website		

Circle Address Type	Ofc 1 – Add'l Ofc – Business – Billing – Other (specify type)	Ofc 1 – Add'l Ofc – Business – Billing – Other (specify type)
Street Address		
City, State ZIP		
Contact Person		
Phone Number(s)		
Fax Number(s)		
E-mail Address(s)/ Website		

3. IDENTIFICATION OF KEY PERSONNEL *Please provide key personnel with whom CAP or MPT may need to communicate, including, but not limited to, Administrator, Office Manager, CEO, CFO, Medical Director, Lab Director, Director of Nursing, Accountant/Controller. Use additional paper if necessary.*

Name			
Title			
Direct Phone			
Cell or pager #			
Fax #			
E-mail Address			



APPLICATION FOR MUTUAL PROTECTION TRUST (MPT) COVERAGE
FOR ENTITIES RELATED TO A MEMBER'S PRACTICE

Page 5 of 14

Do not list:

- Registered Nurses who are not performing cosmetic procedures such as collagen or Botox injections, laser treatments, or dermabrasion
- Licensed Vocational Nurses
- Medical Assistants
- Technologists or Technicians
- Clerical Employees

Name of <i>Non-Physician Direct Health Care Providers</i>	Medical Specialty, Job Function, or Type of Services Rendered	License Number	Role in Entity: O = Owner E = Employee IC = Independent Contractor U = User of facility	Hours per week worked for Entity

5. CLASSIFICATION OF ENTITY

a) Please check all boxes which describe the medical service classification(s) for this Entity:

- Medical Group Surgery Center Treatment Center Laboratory

Other (please describe): _____

b) Provide a practice description. Use Remarks Section at end of application if more space is needed or Submit a brochure or business plan.

Submit copies of all current *Facility Accreditations/Certifications*



6. FACILITY INFORMATION

a) TO BE COMPLETED BY A SURGERY CENTER.

Please provide the number and types of surgeries performed per month in the following categories:

	<u># surgeries/month</u>	<u>type of surgeries</u>
MPT owners		
MPT users (non owners)		
Non-MPT owners		
Non-MPT users (non owners)		

b) TO BE COMPLETED BY A TREATMENT CENTER, I.E., RADIATION ONCOLOGY CENTERS, DIALYSIS CENTERS, RADIOLOGY IMAGING CENTERS, ETC.

Please provide the number and types of treatments performed per month in the following categories:

	<u># treatments/month</u>	<u>type of treatments</u>
MPT owners		
MPT users (non owners)		
Non-MPT owners		
Non-MPT users (non owners)		

c) TO BE COMPLETED BY A LABORATORY.

Approximate # of specimens per month: _____
Generally, what types of specimens or lab tests are handled at the facility? _____
Is the laboratory facility a reference lab? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not, is the laboratory facility available to outside patients? <input type="checkbox"/> Yes <input type="checkbox"/> No



7. CLAIMS HISTORY AND RETROACTIVE COVERAGE

You will have no coverage from MPT for any **known** claims or incidents that may lead to a claim or lawsuit. All claims or incidents that may lead to a claim or lawsuit should be reported to your current malpractice carrier/insurer before terminating your existing policy. (Coverage for any such lawsuits, claims, or incidents under your current malpractice insurance policy depends upon the terms of that policy.)

SECTION A – Your Claims History (Required of All Applicants)

Definition: A Claim is a demand for money from a patient or on a patient's behalf, a 90-day notice of intention to sue, a lawsuit, a counterclaim, or a demand for arbitration.

1. Have any malpractice Claims ever been made against the Entity? Yes No
(This includes all cases which have been dismissed or "dropped").

If you answered "Yes" to Question 1:

a. Number of Claims: _____

- b. Have all Claims been reported to your current/past malpractice insurer(s)? Yes No

Whether or not you believe that the Entity and/or any person acting on behalf of the Entity was at fault, are you aware of:

2. Any incidents resulting in the injury, death, or damage to a patient of the Entity that may lead to a Claim against the Entity and/or any person providing services on behalf of the Entity? Yes No
3. Any contentions of medical malpractice, any allegations of injury or death caused by medical treatment, any written or oral threats of legal action, and/or any letters, written reports, or oral complaints about the medical care of a patient of the Entity, including, but not limited to a patients of the Entity's current and former employees, independent contractors, associates, or any other person related to the practice of the Entity? Yes No

If you answered "Yes" to Questions 2 or 3:

a. Number of incidents, threats, contentions, or complaints _____

4. Ever having been subpoenaed for a deposition involving the medical care of a patient with whom the Entity is or was involved (other than as an expert witness)? Yes No

If you answered "Yes" to any of the questions in Section A, please complete a Claim Form for each Claim or incident.

SECTION B – Retroactive Coverage (For Applicants Seeking Retroactive Coverage)

By checking "Yes" on the Obligation of Disclosure on Page 8 of the Application for Entities Related to a Member's Practice, you are applying for Retroactive Coverage for the Entity from MPT. (This coverage is also known as "prior acts" coverage or "nose" coverage.) If you are not requesting Retroactive Coverage, please check "No" on Page 7 and complete the balance of the Obligation of Disclosure.

If the Entity is approved for Retroactive Coverage, you will receive a Certificate of Coverage with a specified Retroactive Coverage Date. Thereafter, subject to the terms, conditions and exclusions of the MPT Agreement, the Entity will be entitled to the Claims defense and Claims payment services described in Article VIII of the MPT Agreement for any **unknown** incidents that may lead to a Claim or lawsuit arising out of Occurrences that happen after the Retroactive Coverage Date specified in the Certificate. Retroactive Coverage is not available for any time when the Entity had no medical malpractice coverage, for any time when the Entity had occurrence-type coverage, or for any time that the Entity provided professional services outside of California.



8. OBLIGATION OF DISCLOSURE

California law requires that you disclose to MPT any information known to you that may influence MPT's decision to approve or deny your application for Entity coverage, including the information you provided in Sections A and B on the previous page. You also have an obligation to inform MPT of any information that becomes known to you between the date of your signature below and the date Entity coverage with MPT becomes effective that would change your answers to the information provided in Sections A and B on the previous page. You may report any additional information to MPT Membership Entity Underwriting Department by calling (213) 576-8532 or 800-252-7706.

YES, I hereby apply for Retroactive Coverage from MPT for my Entity for any **unknown** incidents that may lead to a Claim or lawsuit arising out of Occurrences in California that happen on or after the Entity's Retroactive Coverage Date which will be verified by MPT. I represent and warrant that the Entity has and will continue to maintain uninterrupted claims-made professional liability coverage for all Professional Services rendered during the Retroactive Coverage Period for which I am now seeking Retroactive Coverage for the Entity from the Mutual Protection Trust. I further represent and warrant that the Entity will maintain its current professional liability coverage up to its effective date of coverage with MPT. I make this representation with the understanding that, should a later investigation reveal that the Entity did not maintain continuous claims-made professional liability coverage, MPT is entitled to deny all Claims defense and Claims payment services for any Claim arising out of professional services that were rendered, on behalf of the Entity, to patients during the Retroactive Coverage Period. I also make this representation with the understanding that failure to meet this obligation of disclosure may result in the termination of Entity coverage with MPT and the loss of professional liability coverage for all malpractice claims.

Submit a copy of *current proof of coverage* showing retroactive date of coverage for the named Entity if applying for such coverage.

NO, I decline Retroactive Coverage for the Entity from MPT.

This Application for Retroactive Coverage is deemed part of your Application for Membership in MPT and is incorporated by this reference into the MPT Agreement.

By my signature on the "DISCLOSURES" (page 13 hereof), I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ of _____, _____
Day Month Year

in _____, _____
City State

In order for MPT to provide retroactive coverage (also known as prior acts or nose coverage), your Entity must meet the following requirement:

- Entity must maintain continuous coverage up until the effective date of Entity coverage with MPT, and provide proof of such Entity coverage to MPT.



APPLICATION FOR MUTUAL PROTECTION TRUST (MPT) COVERAGE
FOR ENTITIES RELATED TO A MEMBER'S PRACTICE
Page 9 of 14

9. CARRIER INFORMATION

Name of Carrier	Exact Dates of Coverage From Mo/Yr	To Mo/Yr	Liability Limits	Policy Number(s)

Was tail coverage purchased for this Entity? Yes No

If yes, please provide a copy of your tail coverage endorsement.

Please submit a copy of the declaration page(s) or other documentation showing continuous coverage for the Entity from requested retroactive coverage date to present.

10. MISCELLANEOUS INFORMATION Any "Yes" answers below must be explained in the remarks section at the end of this application.

a. Is this Entity engaged in any activity other than the practice of medicine (e.g., I.P.A.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Does this Entity provide medical services, (e.g., laboratory, x-ray, physical therapy, etc.) to individuals who are not patients of any of the physicians listed in Question 4? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Does this Entity provide facilities, equipment, personnel or administrative services to direct health care providers (physician and non-physician) not listed in response to Question 4? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you share office space or staff with, lease office space to, or bill for any direct health care providers (physician and non-physician) not listed in Question 4? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Do you need professional liability coverage for any non-physician providers listed in Question 4? An additional application is required for most of these providers. (Please contact MPT for an Application for Employees or Persons Related to a Member's Practice.) <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Has your Entity/group ever been investigated or audited by a governmental or regulatory agency? <input type="checkbox"/> Yes <input type="checkbox"/> No
g. Has any company ever declined, cancelled, refused to renew, restricted, or surcharged professional liability insurance for the Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No
h. Does the Entity manufacture, sell, or distribute any drug, pharmaceutical, medical device, cosmetic products, herbal products, or other products to any persons or patients either in person or online? <input type="checkbox"/> Yes <input type="checkbox"/> No
i. Does the Entity own any other Entity or is this Entity under common ownership, the control of, or associated with another Entity, parent or subsidiaries? <input type="checkbox"/> Yes <input type="checkbox"/> No
j. Is the Entity a party to any joint venture agreement or any other contract under which professional or business activities are or will be conducted in conjunction with any other person, Foundation, or Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No



APPLICATION FOR MUTUAL PROTECTION TRUST (MPT) COVERAGE
FOR ENTITIES RELATED TO A MEMBER'S PRACTICE
Page 10 of 14

11. PRIOR PROVIDERS *If more space is needed, copy this page for use and submit.*

List physician and non-physician direct health care providers formerly associated with the Entity within the past five years. For examples, please refer to Question 4b for types of non-physician direct health care providers to list.

Check here if none

Name	Medical Specialty, Job Function, or Type of Services Rendered	Role in Entity: O = Owner E = Employee IC= Independent Contractor U = User of facility	Period of Service with Group From To Mo/ Mo/ Yr Yr	Malpractice Carrier and Limits of Liability	Hours per week worked for Entity

If you listed any providers above, please answer the following questions. If you checked "none," please go straight to Question 12.

DEFINITIONS

Tail Coverage:

Coverage that converts "claims made" coverage into "occurrence" coverage. Generally, "occurrence" policies provide coverage for claims based on acts, errors or omissions during the policy period even if the claim is not made until after the policy expires. "Claims made" policies typically limit coverage to claims made against the insured and reported to the company *during the policy period*. Most professional liability (e.g., medical malpractice) policies in California are "claims made" policies. Please check with your broker or current insurance carrier.

Vicarious Liability Coverage:

Coverage for the Entity's potential liability for the acts, errors or omissions of a person or another Entity. Examples of persons for whom an Entity may be liable include, but are not limited to, physician and non-physician employees, independent contractors, and directors and officers. These persons may be full-time, part-time, or temporary personnel. (This is coverage for the Entity, not the individual.) Please check with your broker or current insurance carrier.

a. Was tail coverage purchased for each provider listed in Question 11 at the time of departure from the Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Was vicarious liability coverage purchased for the Entity when those listed in Question 11 left this Entity? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. For those direct health care providers previously associated with the Entity who were covered under the Entity, do you wish MPT to provide tail coverage on behalf of those direct health care providers? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you wish MPT to provide vicarious liability coverage to the Entity for its vicarious exposure in connection with the previously associated direct health care providers listed in Question 11? <input type="checkbox"/> Yes <input type="checkbox"/> No



12. ENTITY LIMITS OF LIABILITY

- Check here if you wish to receive a cost quote. Quotes will be provided after all required information is received.**

***Note:** If the Entity has any non-MPT-covered Healthcare Practitioner(s) and a Claim arises out of his/her/their acts, errors or omissions, the Limit of Liability available to the Entity of \$1 million per Claim will not apply unless the non-MPT covered Healthcare Practitioner(s) has/have insurance, liability coverage or right to indemnification and the limit(s) of liability of such insurance, liability coverage or right to indemnification has/have been exhausted.*

If, however, a Claim arises out of the acts, errors or omissions of one or more MPT Members, the Limit of Liability available to the Entity may be shared with or separate from the limits of liability of the Member(s).

Please indicate with a check mark the preferred option with regard to limits of liability requested for Entity coverage.

- A Shared Entity Limit of Liability of \$1 million per Claim arising out of an Occurrence upon which the Claim is based with an aggregate limit of \$3 million for all Claims first reported in any one calendar year.**
- A Shared Entity Limit of Liability of \$2 million per Claim arising out of an Occurrence upon which the Claim is based with an aggregate limit of \$4 million for all Claims first reported in any one calendar year.** To obtain this Entity Limit of Liability all direct health care providers (physicians and non-physicians) associated with the Entity must carry professional liability coverage with a limit of at least \$2 million/\$4 million.

Shared Entity Limit of Liability

Definition:

A **Shared** Entity Limit of Liability for the Entity means that in the event the Claim arises out of an Occurrence in the conduct of Professional Services for the Entity by one or more of the Members, the limits of liability of the Member(s) whose acts, errors or omissions gave rise to the Claim shall be shared with the Entity, subject to all of the terms, conditions, limitations, and exclusions of the MPT Agreement, and the Declaration of Entity Coverage.

- A Separate Entity Limit of Liability of \$1 million per Claim arising out of an Occurrence upon which the Claim is based with an aggregate limit of \$3 million for all Claims first reported in any one calendar year.**

Separate Entity Limit of Liability

Definition:

A **Separate** Entity Limit of Liability for the Entity means that in the event the Claim arises out of an Occurrence in the conduct of Professional Services for the Entity by one or more of the Members, the limits of liability afforded to the Entity shall be in addition to and separate from (not shared with) the limits of liability of the Member(s) whose acts, errors or omissions gave rise to the Claim, subject to all of the terms, conditions, limitations, and exclusions of the MPT Agreement and the Declaration of Entity Coverage.



APPLICATION FOR MUTUAL PROTECTION TRUST (MPT) COVERAGE
FOR ENTITIES RELATED TO A MEMBER'S PRACTICE

Page 12 of 14

DISCLOSURES

REPRESENTATIONS AND WARRANTIES: I guarantee the truth, accuracy and completeness of all statements and answers provided in this Application. I understand that MPT will rely upon these statements and answers in making the decision to approve or deny this Application. No facts known to me and all employees or other persons related to the practice of the Entity have been withheld. I understand that if any material facts have been withheld, the Entity will not be entitled to coverage for any Claim arising out of such withheld facts and coverage for the Entity may be rescinded. I agree on my behalf and on behalf of any other authorized representative of the Entity to immediately notify MPT of any change to the statements and answers provided in this Application. I acknowledge that coverage through MPT is governed by the MPT Agreement. I further understand that professional liability coverage does not become effective until this Application has been approved and payments have begun.

ARBITRATION: I agree that any dispute or controversy arising out of or in connection with this application shall be submitted to, determined and resolved by, binding arbitration in Los Angeles, California. The arbitration shall be conducted pursuant to Article X of the MPT Agreement.

REFERENCES: I understand that in order to provide this Entity with professional liability coverage, Mutual Protection Trust must have reasonable access to all information concerning this Entity and the shareholders/partners, employees, independent contractors and users of this Entity. Therefore, as the representative of this Entity, I authorize and direct any government agency, medical society, physician, hospital, insurance company, underwriter, insurance agent or credit reporting agent contacted by or on behalf of MPT to furnish any information concerning this Entity and the shareholders/partners, employees, independent contractors and users of the Entity which MPT may request. I also agree that any person or organization which furnishes information to Mutual Protection Trust pursuant to this authorization, together with the officers, directors, agents and employees of such person or organization, will not be liable to me, this Entity, or its shareholders/partners, employees, independent contractors or users in any way for furnishing such information even though the information may be incomplete or incorrect.

I warrant that, in my capacity as the representative of this Entity, I have been authorized by the physician and non-physician members of this Entity to receive confidential information from MPT on claims activity, MPT Peer or Practices Review activities, or any other information which may be related to or may affect the physician memberships and/or the professional liability coverage for the non-physicians and/or the Entity.

Print Name of Authorized Representative

Title

Signature

Date



ENTITY CLAIM FORM

Photocopy as Needed

**INFORMATION REGARDING A LAWSUIT, CLAIM OR DEMAND FOR
 ARBITRATION OR INCIDENTS WHICH COULD LEAD TO THE SAME**

1. Name of Patient: _____ 2. Age: _____ 3. Sex: _____
 4. Name of Primary treating physician(s) & relationship of treating physician(s) to Entity: _____
 5. Date of Incident: ____/____/____ 6. Location: _____
 7. Insurance Carrier: _____ 8. Other Defendants: _____
 9. Present Status: Incident Only 90-Day Notice Suit Filed Suit Served

Arbitration

- Open Reserve Amount \$ _____
 Closed Closing Date: ____/____/____
 Method of Closing:
 Dismissed
 Defense Verdict
 Settled Amount paid on your behalf: \$ _____ Total Settlement: \$ _____
 Judgment Amount paid on your behalf: \$ _____ Total Settlement: \$ _____

10. Patient's allegations or circumstances brought to your attention: _____

 11. Condition and diagnosis at time of incident: _____

 12. Dates and description of treatment rendered: _____

 13. Condition of patient subsequent to treatment (and dates of follow-up treatment): _____

 14. Describe the nature of the injuries your patient claims were sustained: _____

I understand that MPT will not provide either Claims defense or Claims payment services on behalf of the Entity for legal activities against the Entity arising out of professional medical services, as described above, rendered to the above-named patient.

Signature _____ Date _____

On behalf of Entity (name): _____

